

Surgeon Cire. M. Sect. for East Command INDEX
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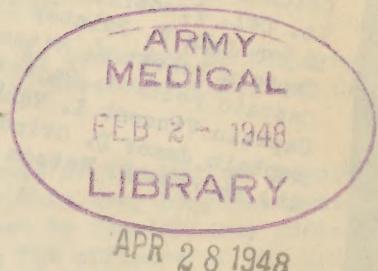


VOL III - NO 2

JURGEON'S CIRCULAR LETTER



1 FEB 1948



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Organization of the Medical Section

The following is a list of commissioned personnel currently assigned or attached to the Medical Section:

Brig. General James A. Bethel
Colonel John C. Fitzpatrick
Lt. Col. Frederick H. Gibbs

Surgeon
Deputy Surgeon
Executive Officer

Lt. Col. Frederick H. Gibbs
Lt. Edwin W. Payne

Chief
Assistant

ADMINISTRATIVE BRANCH

Colonel John C. Fitzpatrick
Lt. Col. Frederick H. Gibbs
Major John V. Painter
Captain Robert E. Watson
Captain Felix G. Rajecski
Captain Vincent I. Hack
Captain James D. Grindell
Lt. Maurice F. Watson

Director
Deputy Director
Chief, Supply and Fiscal Branch
Supply and Fiscal Branch
Chief, Plans and Operations Branch
Plans and Operations Branch
Plans and Operations Branch
Plans and Operations Branch

Lt. Col. Wilfred A. Emond
Major Sam A. Plemmons

Director
Deputy Director

PERSONNEL DIVISION

Colonel Thomas C. Daniels
Colonel George N. Schuhmann
Colonel R. E. Blount
Lt. Col. Warner F. Bowers
Lt. Col. R. L. Colhoun
Major Kermit E. Jones

Dental Consultant
Preventive Medicine
Medical Consultant
Surgical Consultant
Nursing Consultant
Sanitary Engineer

CONSULTANTS

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GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

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NUMBER 2

1 February 1947

PART I

ADMINISTRATIVE

<u>SUBJECT</u>	<u>SECTION</u>
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I. Course of Instruction in Hospital Administration.

The first class in Hospital Administration to be conducted by the Army Medical Department was held at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas, 10 November 1947.

The purpose of the course is to qualify officers of the Medical Department to function efficiently in the administrative positions within Army hospital systems. The course will be of four months duration. Applicants must be Regular Army officers in either the Medical Service Corps or Army Nurse Corps. The officers of the Medical Service Corps must have completed five years active commissioned service as of 1 November 1947. The officers of the Army Nurse Corps must have completed five years administrative experience as of 1 November 1947 in the capacity of Chief Nurse or Assistant Chief Nurse in an Army hospital.

It is the plan of the Medical Department to repeat this course at various intervals.

II. Hospital Funds.

Many medical installations are not making effective use of hospital funds, as evidenced by monthly statements which show that numerous funds remained unused for several consecutive months. Hospital Funds have been established "to procure facilities, equipment, supplies or services which contribute to the welfare, comfort, pleasure, contentment, and mental or physical recovery or improvement of patients in the hospital". (Paragraph 18c AR 40-590). Wasteful or extravagant use of hospital funds will not be recommended, however, the proper use of these funds can contribute materially to the patients' benefit. Adequate funds are available, both at General Headquarters, Far East Command, and major subordinate command levels, to replace disbursed monies up to maximum levels.

Facilities, equipment, supplies and services which are desired may be purchased directly from the hospital fund concerned. For the convenience of individual hospital

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funds a purchasing agency at the San Francisco Medical Depot has been established to procure and ship to this command items desired by the various hospitals. Paragraph 17, GHQ FEC Circular Number 60, dated 29 May 1947, outlines the procedure for using this service. It is of necessity a slow process to procure property from the zone of interior, however, by complying with paragraph 17 a through f of reference circular in the method of requisitioning and in submitting all information required, much time can be saved.

III. Two Hundred Medical and Fifty Dental Internships Will Be Offered by Army in 1948.

Two hundred medical and fifty dental internships will be offered by the Army in 1948 to be filled by recent medical and dental school graduates.

The internships will be for a period of one year of active duty. They will be rotating and will include the following services:

(a) Medical Internships:

- | | |
|--|------------------------|
| (1) Medicine | (6) General Surgery |
| (2) Neuropsychiatry | (7) Urology |
| (3) Pediatrics and Contagious Diseases | (8) Orthopedic Surgery |
| (4) Laboratory | (9) Ophthalmology and |
| (5) Obstetrics and Gynecology | Otolaryngology |

(b) Dental Internships:

- | | |
|------------------------------|--------------------------|
| (1) X-Ray and Oral Diagnosis | (4) Periodontia |
| (2) Operative Dentistry | (5) Prosthetic Dentistry |
| (3) Oral Surgery | |

Pay scales for interns as first lieutenants will be in accordance with existing regulations covering commissioned officers' pay and allowances. Credit for purpose of pay is given in accordance with length of military service. Subsistence and rental allowances are determined by the marital status of the intern; additional subsistence and rental pay is provided for officers who are married or have other dependents.

Qualifications required for application are:

(a) Medical interns:

A male graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association, who is eligible for appointment as a medical officer in the Officers' Reserve Corps of the Army. Graduates of foreign schools are not eligible.

(b) Dental interns:

Citizens of the United States; graduates of approved dental schools (now completing fourth year of dental training); not over 30 years of age on 1 July 1947; have made no agreement to accept an internship appointment in any other institution; and meet the physical standards for appointment in the Dental Corps of the Regular Army. (AR 40-105).

There will also be 350 fully approved residencies for periods of one, two and three years, depending on the specialty desired and previous experience of candidate, in various Army General Hospitals in 1948 which will include:

- | | |
|--------------------------------|---------------------------------|
| (a) Cardiology | (c) Dermatology and Syphilology |
| (b) Contagion and Tuberculosis | (d) Internal Medicine |

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| (e) Pediatrics | (l) Surgery |
| (f) Physical Medicine | (m) Thoracic Surgery |
| (g) Anesthesiology | (n) Urology |
| (h) Obstetrics and Gynecology | (o) Neurology |
| (i) Ophthalmology | (p) Pathology |
| (j) Orthopedic Surgery | (q) Psychiatry |
| (k) Otolaryngology | (r) Radiology |

Qualifications required for application as residents are:

Regular Army Medical officers or applicants for the Regular Army who are graduates of an approved medical school (a male graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association, who is eligible for appointment as a medical officer in the Officers' Reserve Corps of the Army - graduates of foreign schools are not eligible.) and have completed at least one year of rotating internship in a hospital approved by the Council on Medical Education and Hospitals of the American Medical Association may be appointed as assistant residents, resident or senior resident whichever is commensurate with their professional background.

IV. Medical Geneticist Arrives in Japan for Duty with Atomic Bomb Casualty Commission.

Lt. Ray C. Anderson, Medical Geneticist, has arrived in Japan to join the staff of the Atomic Bomb Casualty Commission. The Commission is establishing research and experimental laboratories in Kure so that a long-range study of Hiroshima and Nagasaki survivors may be initiated.

V. Colonel Goriup New Chief Medical Service Corps.

Col. Othmar F. Goriup, has been appointed as the first Chief of the recently created Medical Service Corps of the Army Medical Department.

Col. Goriup graduated from the University of Pittsburgh in 1929 with a PhG degree and from St. Bonaventure in 1939 with a Bachelor of Science degree. He is a member of the American Pharmaceutical Association, American Chemical Society, American Society of Hospital Pharmacists, Kappa Psi, pharmaceutical fraternity, and a fellow of the American College of Apothecaries.

In reference to the outstanding qualifications that Col. Goriup has for the new Medical Service Corps post, mention is made of the distinguished record he made during the war in Air Transport Command. Last March he was awarded the Legion of Merit for his exceptional services in assisting in the development of the program for air evacuation of the wounded and for improvement in the medical service of the Air Transport Command.

From March 1941 to June 1942 he was Administrative Officer at the Station Hospital at Langley Field, Virginia. From June 1942 until October 1945 he was Chief, Supply and Operations Division and Administrative Assistant in the Office of the Surgeon, Headquarters, Air Transport Command, Washington, D.C. Since August 1946 Col. Goriup has occupied the position of Chief of the Allotment and Procurement Branch in the Office of the Air Surgeon.

VI. Optometric Adviser to the Surgeon General Appointed.

Dr. Harry Ward Ewalt, Jr., of Pittsburgh, Pennsylvania, has been appointed

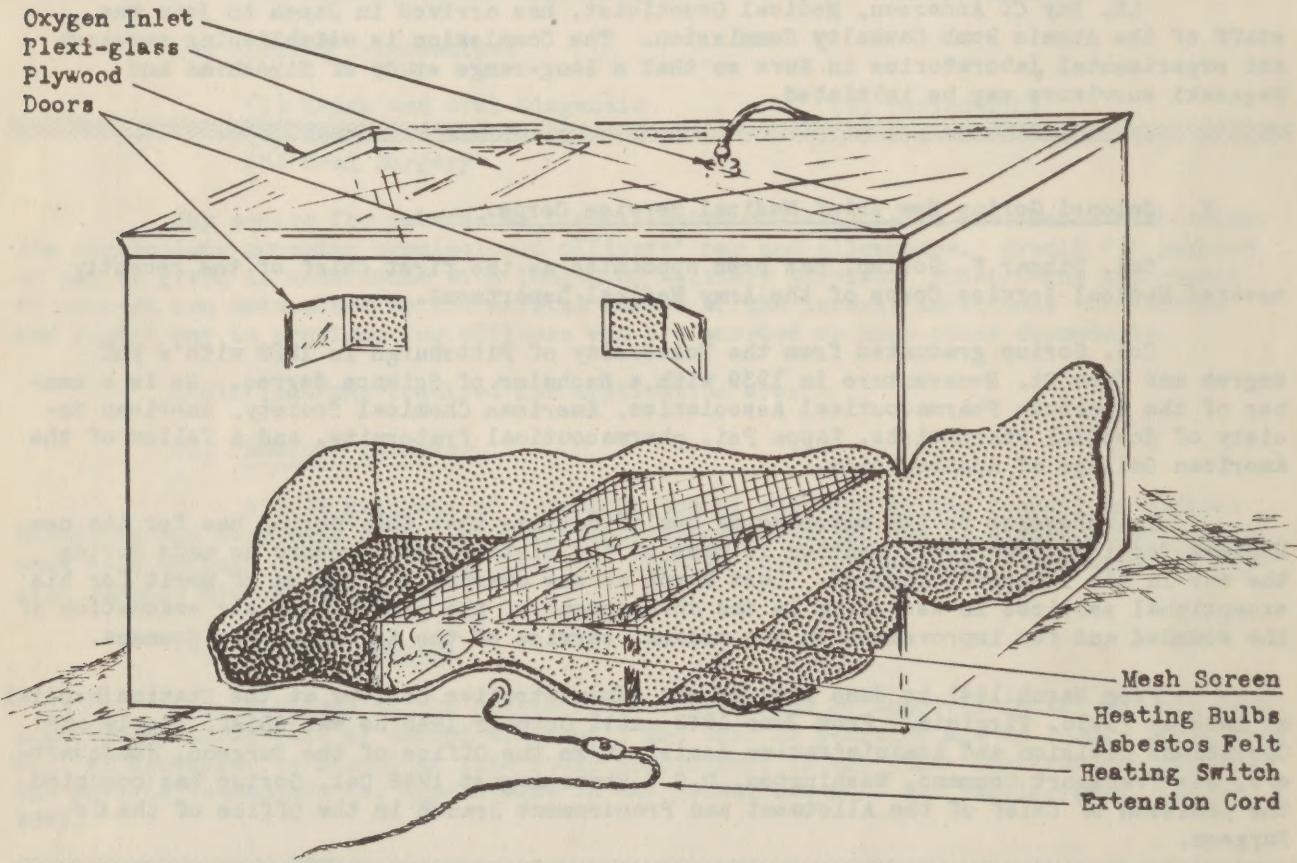
Optometric Adviser to the Surgeon General of the Army.

This appointment was made as part of the Army's program to carry out the provisions of the Medical Service Corps Act signed by President Truman, which provides for the commissioning of optometrists in the Regular Army. The primary purpose of a consultant will be to advise The Surgeon General on the formulation of sound policies in all phases of optometry to the end that the optometry standards of the Army are maintained at the highest possible professional plane.

VII. Infant Incubators.

A tragic happening occurred in this command when a new-born infant succumbed to burns. The cause was a fire within it's incubator. To raise the infant's basket a pillow was placed beneath the basket and upon the blocks used as a support. The cloth of the pillow evidently came in contact with the heat bulbs and was thus ignited.

Utmost care must be exerted and screening of the complete area over the heating units is mandatory to prevent combustible materials from being in contact with either the heat element or wiring. The following sketch will show proper assembly of an infant incubator.



VIII. Venereal Prophylactic Kits, by Captain Chester H. Davis,
Medical Section, GHQ, FEC.

It is the Medical Department's responsibility to procure, store and issue prophylactic items. Much time, study and effort has been spent by the Medical Department to furnish the most effective chemical and mechanical prophylactics packaged to withstand reasonable handling and storage time. However, in the storage and issue of these items investigation has shown that they are often carelessly handled.

Mechanical prophylactics, being a rubber product are subject to deterioration caused by both heat and long storage. Tests made in laboratories and at using levels have shown that in some instances as high as 85% of these items were defective. They were difficult to unroll, gummy, easily torn and of poor elasticity. A study revealed that the deterioration was due to long periods of storage, particularly under conditions where excessive heat was prevalent. This conclusion was further substantiated in that the percent found defective in newer stocks was negligible.

Chemical prophylactic kits contain a soap impregnated cloth which when exposed to dampness becomes moldy, loses its lathering property, and may become so unsightly that personnel refuse to use it. The soap impregnated cloth is an important item of the kit, and when it becomes unfit for use much of the prophylactic value of the kit is lost. Screening of stocks of this item has shown as high as 98.5% of one lot was defective. Part of these defective items was believed to be caused by poor packaging; yet stock from the same lots and in other commands were found to be in a usable condition.

Both chemical and mechanical prophylactics are considered an important factor in the control of venereal disease. Every agency of the Medical Department which has to do with the requisitioning, storage or issue of these items should again have it brought to its attention that long storage will cause deterioration of both items; excessive heat will cause deterioration of mechanical prophylactics, and moisture will cause deterioration of the chemical prophylactic kits.

IX. Recent Department of the Army and FEC Publications.

AR 40-10, C5, 21 October 1947. Medical Department - The Medical Corps - General Provisions.

AR 40-1705, Cl, 7 November 1947. Medical Department; Medical Supplies.

AR 40-1005, DA, 17 November 1947. Medical Department - Reports, Returns and Records.

Cir 22, 15 October 1947, Sec I. Appointment of Female Officers to Army Nurse Corps and Women's Medical Specialists Corps, Medical Department, Regular Army; Sec V. U.S. Army in World War II (Official History Being Prepared)

Cir 26, 21 October 1947, Sec I. AR 30-2135, Laundries and Dry Cleaning Plants, Changed; Sec V. Film and Film Strip.

Cir 29, 24 October 1947, Sec I. Appointment of Female Officers to the A.N.C. and Women's Medical Specialist Corps, Medical Department, Regular Army.

Cir 35, 5 November 1947, Sec III. Hospitalization and Evacuation in Zone of Interior. Cir 59, WD, 1947, Amended; Sec VI. Organized Reserve Corps, Except General Officer, Reserve Officers in the Army Medical Service Corps.

Cir 36, 6 November 1947. Responsibilities for Automotive Equipment. Page 31, Medical Department.

Cir 38, 7 November 1947, Sec I. Army Statistical Data.

Cir 39, 10 November 1947, Sec VII. Records Service Branch, AGO (Discontinued); Sec VIII. SB 38-7, Regulated Items List (Changed).

Cir 41, 12 November 1947, Sec VII. Rescission 8 Series T/O&Es.

Cir 42, 12 November 1947. Furnishing of Services in Connection with Training of Foreign Military Personnel in the United States; Sec II. Par 5h, Medical Service.

Cir 50, 20 November 1947, Sec I. AR 40-5 changed (Annual Report of Medical Dept. Activities); Sec II. AR 40-2010 changed (Annual Report of Medical Dept. Activities).

Cir 51, 21 November 1947. Appointment of Commissioned Officers in Medical and Dental Corps, Regular Army.

Joint Army & Air Force Adjustment Regulations 1-1-1, DA & AF, 13 November 1947. Personnel, Determination of Departmental Status.

WD Memo 40-590-5, 20 November 1946. Admission of Veterans Administration Beneficiaries to Army Hospitals.

Bulletin #1, DA, 12 November 1947, Sec I. Transfer Order 1. (Dept. of Army to Dept. of Air Force)

Supply Bulletin 38-7, DA, 9 October 1947. Regulated Items, par c, Medical Department.

WD Pamphlet 29-11, Cl, 23 October 1947. Movement Regulations for Oversea Movement of Units, Casuals, Replacements, and Individuals.

Cir 106, GHQ, FEC, 14 November 1947. Medical General Laboratory Service.

PART II

SUBJECT	TECHNICAL	SECTION
Rodent Control with 1080		X
Fractures of Head of Radius		XI
VD Control School		XII
Emergencies in Pediatric Practice (In Two Parts) Part II.		XIII

X. Rodent Control with 1080 by Major Kermit E. Jones, MSC, Sanitary Engineer,
Medical Section, FEC

Rats have been recognized as disease carriers from an early day, and the primary role they play in the spread of bubonic plague, epidemic typhus, scrub typhus, Leptospiral Jaundice (Weil's disease), Trichinella spiralis, rat leprosy and Salmonella suis-estifer is known. Rats and mice may also harbor intestinal parasites which occur in man. Those which are of special concern, in addition are trichinosis spiralis and Hymenolepis nana, H. diminuta and *Giardia intestinalis*. The opportunity for food to become contaminated with rat and mice feces is frequent in the butcher shop, in the home, and in storage and transportation. Rats are also known to suffer from spontaneous amebic dysentery similar to that which occurs in man and are therefore possible disseminators of dysentery amebae which are pathogenic for man. It has been recognized that the construction of rat-proof buildings and rigid enforcement of sanitation are fundamentals which must be observed to combat such rodent pests effectively. As a necessary supplement to these procedures, the reduction of the rat population is essential. It is in this phase of rodent control that the most spectacular advances have been made during the past few years.

The importance of reductional control was stressed by the Medical Department of the Army early in the war, and especially when it was planned that troops would invade portions of the world where rodent-borne diseases were known to exist. Research of new rodenticides was further intensified when military action by the enemy cut off supplies of red squill, thallium, and strychnine. Compound 1080 (sodium mono fluoroacetate) was found to be the most important of the rodenticides.

Prior to the war, strychnine, thallium, red squill, zinc phosphide, arsenic compounds, barium carbonate and cyanides were readily available. Thus research for new agents at that time was of a scientific approach rather than one of practical importance. With the advent of war and the resultant shortage of the more effective rodenticides a

strenuous research program with substitute poisons was undertaken.

When the allied invasion forces encountered tsutsugamushi disease with the rat being a principal reservoir of such disease, the importance of the rodenticide project was further emphasized. The Office of Scientific Research and Development provided additional funds to accelerate this work. Close cooperation was maintained with research units of chemical industry, certain Army laboratories and various committees of the OSRD.

Several hundred compounds known to possess toxicity were obtained for tests. The results of the work have been most revealing. As a poison for the control of certain pests, 1080 proved to have no equal. It is highly effective against all species of rats; it is satisfactory in the control of mice; it gives phenomenal control of prairie dogs and ground squirrels, and gives promise of being toxic to other species on which it has not been tested.

1080 is of such toxicity that it is dangerous for general distribution. Whereas the majority of rodenticides are reasonably safe for the unexperienced layman to use, 1080 should be used only by the most expert and careful specialists.

The toxicity of 1080 to dogs and cats is a serious disadvantage of the poison. Because of their great sensitivity, dogs and cats are killed by eating sick or dead rats poisoned by 1080. Pets must be removed from areas where this poisonous agent is exposed and kept away until all baits and rat carcasses have been removed.

Poison 1080 should be dissolved at the rate of 1 ounce to 1 gallon of water. About 2 ounces of the solution should be placed in small tin cups, or other suitable containers such as waxed paper cups placed inside bait boxes as described in TM 5-632. To avoid tampering, bait boxes should be placed where they are as inaccessible as possible, but they should not be placed where their care is hazardous to persons exposing the poison or where such placement would create a problem in recovering the dead rats. Poison 1080 should only be used in water solution and placed in boxes baited with unpoisoned foodstuff unless it is placed in locations inaccessible to children. If 1080 is mixed with foodstuffs and used as poison bait it is possible that rats could carry some of the poisoned bait outside the boxes and thus lead to accidental poisoning of children or pets. The boxes should be plainly marked with a red skull and cross bones, and the word poison (also poison in the native language) written on each side. The word poison should also be painted on the cups with the containers handled carefully even when empty and should not be used for food or drinking water. No one should be allowed to eat any of the food secured for bait purposes nor eat in the vicinity of such bait or in the vicinity of the poison at any time. These habits might easily lead to accidental poisoning. All left-over baits, poison and dead rats should be buried two feet under the ground or in a sanitary fill.

A complete written and dated record should also include notes on the sites where the bait was placed, the amount of poison water used, and the person responsible for placing the bait as well as the data on the efficiency of the project.

For additional information on 1080 reference is made to Article No. IX, Circular Number 12, Medical Section, GHQ, FEC, 1 December 1947, Page 16.

XI. Fractures of Head of Radius, by E. W. Hakala, Colonel, M.C., Chief of Orthopedic Section, 49th General Hospital, Tokyo, Japan

1. Case Presentation: 25 year old white male officer fell on his right hand with partially extended forearm during a football game on 27 October 1947. He had immediate pain on the lateral aspect of the elbow joint. Patient was admitted to this Hospital on 1 October 1947 with a diagnosis of "fracture, simple, complete, head of radius, right". Lateral X-rays with the forearm in mid-position revealed a fracture-line

beginning at the approximate center of the articular surface of the head of the radius, extending distally to the junction of the head and neck and then anteriorly through the cortex at this point. There was minimal displacement of the anterior fragment. AP view of the elbow joint was negative for bony pathology. The humeral condyles apparently were not involved. Examination of the X-rays alone indicated that this was a case which would do well under conservative treatment. Clinical examination, however, revealed complete loss of active supination, 50% loss of active pronation and moderate limitation of flexion and extension; passive motion beyond these extremes was impossible because of severe pain. Because of the limitation of motion, an arthrotomy seemed advisable to determine whether the radial head should be removed. This was performed on 2 October 1947. Through a posterolateral incision, the head of the radius was exposed. A piece of articular cartilage, $1\frac{1}{2} \times 1\frac{1}{2}$ cm in size, had been knocked off the lateral humeral condyle and was impacted edgewise into the fracture-line in the head of the radius. This explained the limitation of motion and the unusual amount of pain on pronation and supination. The head and a portion of the neck of the radius were removed. The ragged edges of the articular cartilage defect on the lateral humeral condyle were trimmed. Patient is making an uneventful recovery.

2. Discussion:

a. Closed versus Open Treatment.

Fractures of the radial head are usually classified as mild, moderate or severe, depending upon the amount of displacement of fragments. Cases with mild displacement are usually treated conservatively, whereas those with moderate to severe displacement usually require removal of the head of the radius. As illustrated by this case, however, one cannot base his decision entirely upon examination of the X-rays. Clinical examination in this group of fractures is as important as in any other pathological condition. This patient had practically no displacement of the smaller fragment, but clinical examination revealed much more limitation of motion than one would expect from examination of the X-rays alone.

b. Timing of Operation.

Myositis ossificans in the ante-cubital region following elbow injuries is notorious for its frequency. Calcification is not always limited to the brachialis anticus muscle, but is frequently capsular as well. The calcification takes place in the hematoma which follows tissue damage. The reason for the frequency of calcification of hematomas in this region, in contrast to hematomas in other body regions, is still unexplained.

The formation of this bone goes through a cycle of three stages. The initial stage is one of increasing amount of lightly calcified bone with indefinite borders as seen by X-ray. This period lasts for two to four months and is succeeded by the second stage in which the amount remains stationary, but the borders become progressively more definitely defined and the density of the mass as a whole increases. This period lasts for three to six months, and is followed by a period of about the same length during which the mass becomes progressively smaller and denser.

Operative trauma, either for removal of the radial head or of the ossifying mass during the first or second stage results in increase in the amount, density and speed of the bone formation. Intensive physical therapy during these stages does the same.

Before its onset, one cannot predict which patient will develop myositis ossificans. The decision to remove the radial head, therefore, must be made before organization of the hematoma begins. Ideally, the operation should be performed within twenty-four hours of injury and usually not later than seven days after injury. There is one group of cases in which removal should be an emergency procedure, done within twelve hours of injury if possible, and through an anterolateral approach rather

than the usual posterolateral incision. These are the cases of radial head fracture with posterior dislocation or subluxation of both bones at the elbow, with resultant severe brachialis anticus and anterior capsule damage. If unoperated, or if operated on after twenty-four hours and through the posterolateral approach, roughly 50% develop varying degrees of myositis ossificans. The anterolateral approach evacuates the hematoma and permits positive hemostasis.

c. Operative Technique.

The usual approach is a posterolateral one through the lateral margin of the origin of the finger and wrist extensors from the lateral epicondyle of the humerus. It is usually necessary to divide the upper fibers of the supinator brevis as they cloak the neck of the radius. This must be done carefully to prevent damage to the posterior interosseous branch of the radial nerve which passes through this muscle. The periosteum is incised around the entire circumference of the radius at the margin of the articular cartilage and reflected distally. The head and enough of the neck of the radius are removed to permit closure of periosteum over the stump. It is preferable to section the radius by means of small encircling cuts with a sharp thin osteotome, rather than with a Gigli saw. The latter method deposits bone dust in the joint and soft tissues which occasionally results in loose bodies in the joint or spur formation on the radial stump. A strong curved elevator placed under the radial neck is necessary as an anvil for efficient use of the osteotome.

The antero-lateral approach requires a thorough knowledge of anatomy in order to avoid damage to the radial nerve or its posterior interosseous branch and still provide adequate exposure for resection of the radial head. Space does not permit the necessarily detailed description of this approach.

d. Post-operative Care.

In general, most authorities immobilize the elbow at 90° and the forearm in mid-position by means of a posterior plaster slab until the skin sutures are removed. All immobilization then is discontinued and twice daily whirlpool and active motion of elbow and forearm are begun. The older the patient, the sooner active motion should be started. It is wise to take once weekly lateral X-rays for four to six weeks to pick up myositis ossificans as early as possible if it occurs. For this same reason the range of elbow and forearm motion should be measured once weekly; if the patient stops gaining, it is usually due to myositis ossificans. Passive forcing of joints, either manually or by carrying weights, is considered detrimental. The emphasis is on active motion. This is carried out until the weekly gains stabilize. Throughout this period, the patient should use the arm unreservedly in his work. One can expect practically a normal range of motion in all directions, depending upon how earnestly the patient works on regaining the motion.

XII. VD Control School, by John F. Harris, Major, MC, VD Control Officer,
Philippines-Ryukyu Command.

The trend of venereal disease in the troops stationed in the Philippines has been rapidly decreasing since November of 1946.

This can be attributed to many factors; the foremost being the intensified VD Educational Program set up in these Islands.

At the September (1947) meeting of the Venereal Disease Control Council, Headquarters, Philippines-Ryukyu Command, it was suggested that an orientation course be given in venereal disease for officers and enlisted men of that command to augment the extensive educational program already in effect.

The VD Control Officer, Philippines-Ryukyu Command, readily took over this

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assignment and after completing the preliminary arrangements for mess facilities, billets, and transportation, the school was opened at the 3rd Medical General Laboratory located on the outskirts of Manila, in the Philippines on 13 October 1947 for a period of five and one quarter days.

Eighteen officers and one hundred and twenty enlisted men attended and completed the five day course consisting of eight hours a day.

On Saturday morning, 18 October, the students were given a certificate of attendance and recommended to their unit commanders as VD control officers or VD control non-commissioned officers.

This is the second school on VD Control that has been set up under the Medical Service, Philippines; the first being completed in March 1947.

Such continued forms of education along with the work of the unit chaplain, the surgeon and the line officers will continue to help keep venereal disease in the military establishment at a minimum.

Below is a lesson plan of the school with the subjects and instructors listed which may be used as a guide if other services or commands wish to carry on such a school.

indoctrination course in venereal disease

DATE	HOUR		SUBJECTS	SPEAKER
	FROM	TO		
13 Oct'47	0810	0830	Opening Remarks on "Indoctrination Course in Venereal Disease".	Col. H. R. Livesay, CO, 3rd Med Gen Laboratory
	0845	0945	The Responsibility of a Commanding Officer in Venereal Disease Control	Col. Henry P. Hallowell, CO, 57th Inf Regt (PS)
	0945	1045	The Purpose of V.D. Control Officers and Non-Commissioned Officers	Capt. R. P. Lewis, G-3, Hqs PHILRYCOM (I&E)
	1045	1145	Why V.D. Control is a Military Necessity?	Lt. Col. J. C. Hooker, CO, 738th MP Bn, Representing the Provost Marshal
	1300	1400	Particular Importance of VD Control Measures for Negro Troops	Major John F. Harris, VD Cont. Officer, PHILRYCOM
	1400	1500	Anatomy of the Male Genitalia	Capt. Earl H. Clendennen
	1500	1600	Anatomy of the Female Genitalia	CO, 2d Sta. Hospital (PS)
	1600	-----	V.D. Movie	
14 Oct'47	0810	0900	Gonorrhea (1) Causative Agent (Microscope with slides) (2) Pathology (Procure anatomical charts and explain same) (3) Symptoms-Illustrate with Navy Pamphlet 1 e(1) Navy 3142 (4) Diagnosis (Microscope with slide explain how slides are made) (5) Treatment (Sulfa-Penicillin-Silver Salts- etc) (6) Preventive Measures: Condom; Pro-Kits; abstinence & projection of energies in other channels (Ex A & R)	Capt. Fred C. Spannaus, Surgeon, 738th MP Dispensary

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HOUR

DATE	FROM	TO	SUBJECTS	SPEAKER
14 Oct'47	0910	1000	Syphilis (1) Same as Gonorrhea(above)	Capt. Shelby Hicks, 46th Ord Sv Group
	1000	1200	Visit to 3rd Med Gen Laboratory (a) See slides on G.C. (b) See slides on Syphilis (c) See how blood tests are run for Syphilis (d) Speaker & Guide Laboratory Officer	Capt. C. A. McWhorter, Laboratory Officer, 3rd Med Gen Laboratory
	1300	1400	Chancroid (1) Discuss same as Gonorrhea above (2) Relationship to Syphilis	Major John F. Harris, VD Control Officer, PHILRYCOM
	1400	1500	Lymphogranuloma Inguinale)same as Gon Granuloma Inguinale)orrhea ab- ove	Capt. Schiewe, Pasig Dispensary
	1500	1600	VD Movie	
15 Oct'47	0810	0910	Approved VD Control Measures (a) Educational Program (Surgeon-Chaplain- I & E and A & R Officers) (1) Exhibit & distribute pamphlets, booklets & posters on VD. (2) Problems concerning VD with newly arrived troops (3) Problems concerning VD with old soldiers (4) Problems concerning VD because of Camp Locations (a) Rural area problems (b) Urban problems	Lt. Col. George K. Fair, Chief Preventive Medicine, PHILRYCOM
	0910	1010	VD and its problems in the Philippines.	Dr. Florencio Cruz, Chief, VD Cont. Section, USPHS for the Philippines
	1010	1110	Leisure hour activities for Military Personnel	Lt. Col. K. Woody, A & R Section, PHILRYCOM
	1110	1200	Procurement of Equipment for a successful A & R	Lt. Ficker, A & R Section, PHILRYCOM
	1300	1400	The Place of the Army Library and Service Club in a Good A & R Program	Miss Margaret Rippere, Miss Evelyn C. Moore, A & R Section, PHILRYCOM
	1400	1500	Moral and Spiritual Welfare in VD Control	Capt. J. F. Albert, Chaplain, Pasig Area.
	1500	1600	V.D. Film	
16 Oct'47	0810	0910	Prophylaxis (1) Maintenance & Operation of Prophylactic stations (2) Use of Mechanical Prophylaxis (3) Demonstration & Use of the "Pro Kit", Chemical Prophylaxis (4) VD Prevention	Maj. John F. Harris, VD Cont. Off, PHILRYCOM

DATE	HOUR		SUBJECTS	SPEAKER
	FROM	TO		
16 Oct '47	0910	1010	Athletics in Control Program	Mr. Ralph Daitz, Athletic Supervisor, PHILRYCOM
	1010	1100	Place of ARC in an Army Controlled Program	Mr. J. E. Duffy, ARC (Manilla Field Director)
	1100	1200	VD Film	
	1300	1600	Visit - 10th General Hospital 1 class to Laboratory 2 class to VD wards and reverse	Have Chaplain Albert accompany the group & Medical Officer
17 Oct '47	0800	0900	Review	Capt. Curtis
	0900	1000	Anatomy Contact Reports	Pathologist - 3rd Med. Gen. Laboratory
	1000	1200	Diseases	
	1300	1600	Tour San Lazaro Contagious Hospital	Have Chaplain Albert accompany Medical Off & groups
18 Oct '47	0900	----	Presentation of Certificates	Col. J. R. Koch, Chief of Chaplains, PHILRYCOM

XIII. Emergencies in Pediatric Practice, by Moe Weiss, Captain, M.C., 35th Medical Station Hospital, APO 713, Kyoto, Japan. Part II.

The remainder of this presentation is devoted to symptoms in infancy and childhood which are of a potentially serious nature and may require emergency treatment. The first such is persistent vomiting, which, irrespectively of cause, not only prevents adequate fluid and food intake, but also disturbs the electrolyte and acid base balances. The causes can be broken down into mechanical, obstructive, infectious, peritonitis, central, reflex, toxic and habit.

1. Mechanical over-distension due to too much food or too frequent feedings, or air swallowing is the most common cause of persistent vomiting under 6 months.

2. Obstructive factors are pyloric and intestinal.

a. Congenital pyloric stenosis is a serious condition, which untreated, has a high mortality of 10 to 15%. It is usually first seen in male infants between 2 weeks to 2 months of age. It is characterized by forcible projectile vomiting with apparent excellent appetite. The vomitus is not bile stained. Constipation and wasting follow. Physical examination reveals the diagnostic gastric peristaltic waves especially following meals and the typical pyloric mass after vomiting. A stomach tube will demonstrate gastric retention. Treatment consists of a trial of medical management consisting of concentrated feeding every 4 hours, emptying the stomach, atropineization and relation followed by surgery if this procedure fails.

b. The vomitus of acute intestinal obstruction usually contains bile, and if unrelieved, later contains fecal matter. Pain, constipation, distention and abdominal shock are present. Volvulus, intussusception, Meckel's diverticulum, defects, deformities, and displacement of viscera, appendicitis and strangulated hernias must be considered. Internal hernias are more apt to occur in infancy, whereas external strangulation hernias are more commonly found in older children.

3. An infection, or the onset of any acute or febrile illness, is often ushered in by vomiting and frequently symptomatically overshadows the pneumonia or otitis.

4. Peritonitis, local or general has vomiting containing bile as a constant symptom.
5. Central causes are present in meningitis or organic brain disease where it is usually projectile and unrelated to meals.
6. Reflex causes are present in pharyngitis with throat irritation, and pertussis, by coughing.
7. Toxic causes are uremia, poisonings, and drugs such as ipecac, calomel, and santonin.
8. Finally no other cause than pure habit can be found. Determining the cause, history and physical examination should determine the quantity, frequency, forcibleness, and character of the vomitus, the relation to meals, the degree of appetite, peristalsis, presence of pain, fever, prostration or evidence of disease. In an apparently healthy child where vomiting is not severe, mechanical factors are probably the cause. If anorexia is present and vomiting does not immediately follow food, improper food or infection is probably the cause. Severe and projectile vomiting occur at the onset of infection, organic brain disease and acute abdominal disease. In the very young male infant pyloric stenosis should be considered, especially if no bile is found in vomitus. Bile is found in peritonitis, intestinal obstruction and in very severe vomiting. The stomach tube, X-ray and fluoroscopy are additional aids in determining the cause. The correct treatment of vomiting depends on removal or correction of the cause, but frequently symptomatic and palliative therapy is helpful. The use of concentrated feedings, reduction of quantity, frequent small feedings, stomach lavage, and the administration of parenteral fluids are all helpful measures while one is searching for and treating the primary cause.

Diarrhea: Diarrhea and diarrheal diseases are statistically no longer the first cause of infant mortality, the death rate now being about 1/15th that of 30 years ago. Nevertheless it remains a problem of grave importance during the summer months and the specific case is still the same pediatric emergency it formerly was. Discussion of summer diarrheas in infants usually precludes true enteric infections caused by specific pathogens of the shigella and salmonella groups, which statistically cause a very minor percentage of cases. The great majority of infantile diarrheas are associated with 2 etiologic factors, hot weather and parenteral infections. The unique susceptibility of infants to diarrhea can perhaps be best correlated with the fact that parenteral infections, fever and external heat precipitate diarrhea by producing a functional impairment of gastric, intestinal and pancreatic epithelium. Reduction of gastric, duodenal and pancreatic secretions has been demonstrated, which, with reduction of gastric acidity is believed to permit over-growth of normally present bacteria which then assume pathogenic properties. The diarrhea that follows is then presumed to be caused by toxins from the primary forms of infection as well as from the irritative action of intestinal bacteria. The diminished secretion produces inadequate digestion, which, with the rapid peristalsis produces impaired absorption. Protein digestion and absorption is least affected, that of fats and carbohydrate greatly so. The most profound disturbance follows loss of water and minerals which produces dehydration and acidosis. The loss of fluids results in diminished plasma volume and hemo-concentration. Plasma proteins, blood viscosity and red cells are relatively increased. However, blood flow from the tissues decrease, resulting in retention of acid metabolites. In addition with fall in renal arteriolar pressure, the volume of urine secreted decreases to the point of suppression, resulting in loss of an important regulator of acid base balance. A great excess of sodium and potassium over chlorine is lost in diarrheal stools through failure of absorption, which results in an acidosis, unless the kidneys compensate by excretion of fluid, or vomiting occurs. However in dehydration with renal shut-down, acidosis is uncompensated.

The mild cases have up to a dozen stools daily, all of fecal nature. Color varies from yellow to green with moderate mucus. Anorexia is present usually with some

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fever and vomiting. The prognosis of such cases is very good. The severe cases may develop gradually or appear suddenly with high fever, prostration, with central nervous symptoms such as excitability, restlessness, convulsions or dullness and stupor. Vomiting is severe, stools occur as frequently as twice each hour, are yellow to green and associated with pain, flatus and offensive odor. Dehydration becomes quickly evident, with depressed fontanelles, dry inelastic skin, dry mouth and tongue, and scanty urine. The more severe cases have exaggerated nervous symptoms and evidence of acidosis in form of exaggerated or "air hunger" type of respiration.

A severe diarrhea demands prompt and energetic measures designed to:

- a. Restore water and alkali loss, thus correcting dehydration, acidosis and central nervous system irritation.
- b. Initiate as soon as possible, a feeding program that will not aggravate the diarrhea.
- c. Treat the parenteral infection with specific therapy if possible.
- d. Treat fever.
- e. Assure rest.

Parenteral fluids should always be given since vomiting limits the oral route. They are best given by continuous intravenous infusion at rate of 60 to 70 cc/lb/day. This method alone, using saline alone, corrects dehydration and renal suppression, often acidosis. As an additional precaution to correct acidosis, 1/6 molar lactate or bicarbonate solutions may be used.

As regards diet, an initial period of starvation of 24 to 48 hours is advisable, followed by use of protein, milk with added sugar, or lactic acid milk. For the very young the acid milk is made by adding 3 cc USP lactic acid to 1 pint of milk. Glucose and amino-acid parenterally, supply additional calories and food. Feedings are increased along with tolerance.

Drugs are not routinely recommended for treatment of the diarrhea, though paregoric or morphine are indicated for severe pain or tenesmus.

Gross Intestinal Hemorrhage: Later in infancy, one of the most important sources of intestinal bleeding is the invagination of one portion of the intestine into another, intussusception. Occurring as it does, most often under 2 years, especially in males between 4 to 12 months, it is the most common cause of acute intestinal obstruction at this age. Intussusception occurs most frequently at the ileocecal region but in only about 10% of the cases is a local abnormality such as a polyp, cyst or diverticulum found. The symptoms are caused by obstruction of the intestine and strangulation of the vessels of the mesentery which is drawn in with the intestine, causing congestion, edema, hemorrhage, and possibly gangrene. The onset of symptoms is sudden, with severe, intermittent pain, marked vomiting of bile stained material, loose stools, with blood, or bloody mucus. There are early signs of moderate shock present with normal temperature and a sausage shaped mass can be felt along the course of the colon or by rectal examination. As the condition continues, the abdomen becomes distended, dehydration and high fever appear with death from shock or peritonitis. The diagnosis of intussusception can usually be made by clinical story of sudden onset of intermittent colicky pain, persistent vomiting, blood and mucus in the stools, some collapse, with little or no fever. The characteristic tumor differentiates it from gastro-enteritis or dysentery. Mortality varies inversely with the promptness that treatment is instituted, being about 10% in cases of less than 24 hours duration and from 50 to 75% in cases of 2 to 3 days duration. Therapy is aimed at immediate reduction by non-surgical or surgical methods. The former employs hydrostatic reposition under anesthesia by means of a pressure enema with saline, for 3 to 4 minutes. If this is

successful, as it is in the early cases, immediate disappearance of the tumor is noted with easy entrance of fluid. If it fails surgery with reposition of the gut with or without resection must be done.

Gross intestinal bleeding with pain, vomiting, distension, shock and intestinal obstruction due to volvulus with circulatory block is not as frequent in childhood as intussusception. Nevertheless, this condition, caused by a twisting of the intestine upon its mesenteric axis, thus occluding the lumen, produces a picture greatly similar to intussusception. The only clear method of differentiation is the absence of tumor.

Two other conditions associated with intestinal hemorrhage and collapse must be mentioned, namely, bleeding from a peptic ulcer in aberrant gastric mucosa, located in a Meckel's diverticulum; and duodenal ulcer. The first is quite rare. Duodenal ulcers are being reported with increasing frequency in infancy in which the first symptom is hemorrhage. X-ray studies are frequently disappointing. The therapy of these 2 conditions is namely supportive with parenteral fluid, rest, transfusions, sedation and feedings as indicated.

Finally, profuse intestinal bleeding of bright red blood, often accompanied by bearing down and straining at stools between evacuations, may be caused by a friable rectal or sigmoidal polyp. Digital and protoscopic examination will usually demonstrate such a polyp occasionally and barium enema may outline such a polyp. Prompt excision should be made.

Croup: Few symptoms in children produce a more alarming picture, or terrify parents more frequently, than croup or respiratory stridor. The common causes are congenital laryngeal stridor, spasmodic and cararrhal laryngitis, diphtheritic laryngitis, laryngospasm of tetany and foreign body of the larynx.

1. Congenital laryngeal stridor usually begins after the first week in life. It is due to abnormalities of the laryngeal and epiglottic structures and is characterized by respiratory stridor, and retraction of the soft tissues of the chest wall. In the absence of excitement or crying, no dyspnea or cyanosis is present. The prognosis in these cases is good. No treatment is necessary. The condition is self limited and usually disappears before the age of 6 months.

2. Spasmodic and cararrhal laryngitis: Certain children between 6 months to 4 years seem to manifest abnormal elements of laryngeal spasm with ordinary laryngitis or rhinopharyngitis. The usual story is that the child is relatively well during the day time but during the night has a metallic or hollow barking cough and gets an attack of marked dyspnea with loud respiratory stridor, chest retraction, hoarse voice, fever and some cyanosis. The attack lasts 3 to 4 hours. The prognosis is good, no matter how alarming the attacks may appear to be. The condition is to be differentiated from laryngeal diphtheria by its sudden onset, mild inflammatory symptoms, the intermittent dyspnea, the daytime remissions, the history of previous attacks and stridor only in inspiration. Treatment of the attacks is directed toward relieving the laryngospasm by use of emetics (syrup of ipecac $\frac{1}{2}$ every 10 to 15 minutes to a child of 2 years) until vomiting occurs, steam inhalations, hot applications to the larynx and sedation.

3. Primary laryngeal diphtheria may simulate simple inflammation at the onset, but soon differs by the gradually progressive hoarseness, cough and stridor throughout the day and night. Dyspnea increases steadily, voice is lost and stridor become expiratory as well as inspiratory. Laryngeal examination reveals a membrane. Laboratory smears and cultures should be taken. Antitoxin should be given immediately, while waiting for the culture. Normal 100,000 units of antitoxin should be given, plus penicillin. Suctioning of the membrane, intubation, or tracheotomy should be done if necessary.

4. Laryngospasm of tetany: Laryngeal stridor of sudden onset without fever

occurs in tetany, which is most common in males, between 3 months to 7 years, practically always associated with rickets. An attack is characterized by sudden inspiratory stridor, pallor, then cyanosis, and sometimes respiratory arrest. The obstruction to inspiration produces cyanosis, asphyxia and unconsciousness which may even go into general convulsions and death. In the ordinary laryngeal spasm, relaxation occurs after 15 to 20 seconds and is marked by a long deep inspiration with a crowing sound. The diagnosis is made by the age of the patient, absence of fever, period of apnea followed by crowing inspiration and clinical signs of tetany: Chvostek's sign, carpopedal spasm and Troussseau's sign. A low blood calcium will, of course, confirm the diagnosis. Laryngoscopic examination may be necessary to exclude a foreign body in the absence of characteristic Chvostek and other signs. Treatment of the attack consists of artificial respiration and cold applications to the face and chest, followed by 10cc of 10% calcium gluconate intravenously.

5. The not common accident in children of aspiration of foreign bodies in the larynx produces a sudden paroxysm of coughing and severe dyspnea. This may dislodge the object. Death will occur if glottic occlusion is complete and unrelieved. If obstruction is partial and the object remains lodged in the larynx, acute laryngitis may be suspected where no history is obtained. The diagnosis of foreign body in the larynx where a history is given or the episode is witnessed is easy. Without this help the condition must always be kept in mind in case of unusual laryngitis, in which case laryngoscopy, fluoroscopy and X-rays are indicated. The value of the latter 2 methods depends on the density of the foreign body. In acute cases, tracheotomy may be necessary. In those where the foreign body is not coughed up, if symptoms persist, laryngoscopy or bronchoscopy is urgently indicated.

Convulsions: Generalized convulsions occur more frequently in infancy and childhood than in any other period of life. The explanation for the convulsive tendency at this age is not clear. It was previously attributed to some peculiarity in the nervous system in the nature of instability, immaturity or failure of inhibitory function of the higher centers, but is now felt to be due to a disturbance of chemical metabolism such as hyperpyrexia, hypoglycemia, uremia, disturbances of acid - base and water balance, anoxemia, asphyxia, or impaired circulation.

Among the causes are; trauma, developmental brain defects, meningitis, encephalitis, brain abscess or tumor, cerebral embolism or thrombosis, or tetany. The onset of many acute infectious diseases, especially those with sudden rise in temperature may be marked by a convulsion which seems equivalent to the chill of an adult. Pertussis is an infectious disease frequently associated with convulsions; here a variety of causes are at play - gastric tetany, asphyxia from severe coughing, cerebral hemorrhage or cortical degeneration. Idiopathic epilepsy may occasionally begin under 2 years of age. Toxic states such as uremia and lead poisoning, and abnormal states such as spontaneous hypoglycemia and asphyxia are associated with convulsions. The concept of overfeeding, dentition, and worms as causes of convulsions is not disputed. Irrespective of cause the manifestations of a convulsion are the same - a sudden violent occurrence of tonic or clonic contractions, lasting from a few moments to a half hour, usually preceded by a loss of consciousness, and followed by a period of profound relaxation, exhaustion or stupor. In differential diagnosis, age of the patient, presence of fever, or focal signs of brain disease, recurrence and duration of the convulsions are helpful. In the new born, cerebral injuries and malformations should be considered first. From 2 months to 2 years, especially in absence of fever, tetany should be considered, sometimes even if fever is present. Under 2 years, afebrile convulsions in the absence of tetany are suggestive of congenital brain defects. After 2 to 3 years idiopathic epilepsy and brain tumor rank high as causes of afebrile convulsions. Convulsions with sudden high fever suggest an acute infection. Convulsions due to brain disease may have associated focal signs including unilateral convulsions. They may recur sooner and may last longer.

Treatment of convulsions should be divided into 3 phases - management of the seizure, prevention of recurrence and removal of its cause:

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Management of Seizure: In most cases, this distressing and alarming event is over before the patient is first seen. If it isn't and is severe, a few breaths of ether, or the injection of sodium phenobarbital I.V. $\frac{1}{2}$ grain for a 6 month infant is best and repeated if necessary. In less severe cases morphine sulfate 1/40 grain for a 6 month old infant, or 4 grains of chloral hydrate, or 4 cc of paraldehyde by rectal tube may be given. In tetany calcium should be given I.V. Traditional remedies like mustard packs and enemas are useless.

Prevention of Recurrence: To prevent a recurrence, immediate therapy must be followed by such sedatives as, bromide, chloral hydrate, or phenobarbital by mouth for several days, the dosage being gradually reduced.

Removal of Cause: As soon as convulsions stop investigations should be made to determine the cause. In many cases a routine history, and a careful physical examination, including neurological study, is sufficient. In others, blood count and urine examinations, blood chemistry, blood Kahn, spinal tap and special X-rays and even electroencephalogram may be necessary. Once the cause is found proper therapeutic measures should be started as soon as practical.

PART III

STATISTICAL

Evacuation:

1. During the period 27 September 1947 to 31 October 1947, the following patients were evacuated from the several major commands:

	AIR	WATER	TOTAL
JAPAN	219	208	427
*KOREA	158	1	159
MARBO	88	2	90
PHILRYCOM	57	58	115

2. The following are the evacuations per thousand strength for the period 27 September 1947 to 31 October 1947:

JAPAN	3.9
*KOREA	3.9
MARBO	5.1
PHILRYCOM	2.3
THEATER	3.6

3. As of 31 October 1947, the following number of patients were awaiting evacuation:

JAPAN	154
KOREA	20
MARBO	12
PHILRYCOM	12

*Patients evacuated by air to Japan from Korea for onward evacuation.

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Hospitalization:

1. The bed status Report as of 31 October 1947 was as follows:

	Total T/O Beds Authorized	Total T/O Beds Established	Total T/O Beds Occupied
JAPAN	4,450	4,450	2,045
KOREA	2,050	1,472	723
MARBO	575	575	274
PHILRYCOM	2,350	1,994	1,391
 THEATER	 9,425	 8,491	 4,433

2. The percent of T/O beds and operating beds occupied for the period ending 31 October 1947 are as follows:

	Percent Authorized T/O Beds Occupied	Percent of Established Beds Occupied
JAPAN	46	46
KOREA	35	49
MARBO	48	48
PHILRYCOM	59	70
THEATER	47	52

3. Tables showing various admission rates are listed below:

ADMISSION RATES PER 1,000 PER ANNUMAll Causes

<u>Week ending</u>	<u>THEATER</u>	<u>JAPAN</u>	<u>KOREA</u>	<u>MARBO</u>	<u>PHILRYCOM</u>
3 October 1947	604	626	703	421	536
10 October 1947	613	697	651	370	482
17 October 1947	603	659	645	417	518
24 October 1947	574	630	608	479	466
31 October 1947	557	576	637	412	504

Disease

3 October 1947	549	575	635	353	488
10 October 1947	544	630	549	286	439
17 October 1947	538	598	569	350	452
24 October 1947	525	586	550	400	422
31 October 1947	493	520	554	349	439

Injury

3 October 1947	55	52	69	88	48
10 October 1947	69	66	102	84	42
17 October 1947	64	61	76	67	66
24 October 1947	49	44	58	79	44
31 October 1947	66	56	83	86	65

Psychiatric

3 October 1947	18	20	12	35	14
10 October 1947	14	12	23	12	12
17 October 1947	12	12	14	12	9
24 October 1947	16	18	18	18	11
31 October 1947	16	14	16	35	15

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ADMISSION RATES PER 1,000 PER ANNUM (Continued)Organic Neurological Disease

<u>Week Ending</u>	<u>THEATER</u>	<u>JAPAN</u>	<u>KOREA</u>	<u>MARBO</u>	<u>PHILRYCOM</u>
3 October 1947	.5	.5	1.2	0	0
10 October 1947	1.2	.5	4.9	0	0
17 October 1947	.5	0	2.5	0	0
24 October 1947	.2	0	1.5	0	0
31 October 1947	.5	.5	1.3	0	0

Common Respiratory Disease

3 October 1947	83	93	105	18	59
10 October 1947	105	135	104	27	65
17 October 1947	95	118	111	29	55
24 October 1947	93	105	115	30	74
31 October 1947	83	92	93	65	64

Influenza

3 October 1947	.5	.5	0	0	1
10 October 1947	2	3.3	1	0	1
17 October 1947	2.1	1.9	4	0	2
24 October 1947	1.2	2.5	0	0	0
31 October 1947	2.2	3.4	1	0	1

Primary Atypical Pneumonia

3 October 1947	5.6	5.1	11	0	4.1
10 October 1947	9.4	9.4	18	3	4.1
17 October 1947	5	7.6	5	0	1
24 October 1947	4.6	4.9	7	0	4
31 October 1947	6.6	7.4	4	0	6

Common Diarrhea

3 October 1947	4.4	1.9	13	0	4
10 October 1947	4.5	.9	15	0	5
17 October 1947	5	1.9	14	0	6
24 October 1947	6.1	3.5	20	0	3
31 October 1947	3.7	2	9	0	4

Bacillary Dysentery

3 October 1947	1.2	1.9	0	0	1
10 October 1947	3	2.4	5	0	4
17 October 1947	.9	1.4	1	0	0
24 October 1947	.5	.5	0	3	0
31 October 1947	.7	.5	0	0	2

Amebic Dysentery

3 October 1947	.9	.5	0	0	3
10 October 1947	0	0	0	0	0
17 October 1947	1.4	.9	1	0	3
24 October 1947	.5	.5	0	0	1
31 October 1947	1.5	0	1	0	5

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ADMISSION RATES PER 1,000 PER ANNUM (Continued)Malaria

<u>Week Ending</u>	<u>THEATER</u>	<u>JAPAN</u>	<u>KOREA</u>	<u>MARBO</u>	<u>PHILRYCOM</u>
3 October 1947	18	1.9	16	9	58
10 October 1947	13	0	20	18	35
17 October 1947	12	.9	3	9	40
24 October 1947	14	1.5	7	1.5	44
31 October 1947	10	.5	5	0	37

Infectious Hepatitis

3 October 1947	5.4	5.6	6.2	0	6
10 October 1947	2.3	1.9	4.9	3	1
17 October 1947	2.8	2.4	2	9	2
24 October 1947	2.2	2	4	3	1
31 October 1947	4.4	5	5	0	4

Mycotic Dermatoses

3 October 1947	4.9	5.6	6.2	3	3
10 October 1947	4.5	4.3	8.6	0	3
17 October 1947	4.5	6.2	2	6	2
24 October 1947	4.1	5.9	3	3	2
31 October 1947	5.6	7.9	5	6	1

Venereal Disease

3 October 1947	73	101	55	30	42
10 October 1947	82	107	68	12	64
17 October 1947	85	108	77	8.7	67
24 October 1947	86	109	86	42	54
31 October 1947	85	108	87	21	59

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Articles for Publication in Circular

It is desired that the Monthly Circular Letter published by the Medical Section, GHQ, FEC be of maximum value to all of the Medical Department personnel in the field. To that end, articles of professional or administrative nature that might be of general interest are needed. All Medical Department officers, as well as the Commanding Officers of Medical Department units, and the Surgeons of the major commands are solicited for articles of administrative or technical value. Such articles should be forwarded so as to reach the Medical Section, FEC, not later than the 20th of the month preceding the publication of the circular in which it is to appear.

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